OFFENDER I.D. DATA

Department of Corrections
WASHINGTON STATE

VISITOR MEDICATION QUESTIONNAIRE

Please Print

Offender Name	DOC Number
Visitor's Name	
Street Address	City, State, Zip
Planned Visit Date	

List any **prescription medication** you require during your visit, **including prescription contraception**. Prescription medication must be in a container properly labeled with pharmacy name, address and telephone number, date, prescription number, patient's name, prescribing doctor, directions for use, medication name, and strength. Medication not readily identifiable by facility staff will be rejected.

Medication and Strength	Direction for Use	Times Normally Taken	Prescribing Doctor

List any **non-prescription medication** you require during your visit. Non-prescription medication must be in their original container.

Medication	Dosage Taken	Times Normally Taken

List any **non-prescription contraception/barrier protection, including condoms,** you are bringing for your visit.

Type	Quantity

Visitor's Signature _____ Date _____

Staff Approval Signature _____ Date _____

Distribution: **ORIGINAL**-Visiting Department **COPY**-Offender Central File